ALABAMA MEDICAID AGENCY
GATEWAY TO COMMUNITY LIVING/LOCAL CONTACT AGENCY RETURN TO COMMUNITY ASSESSMENT TOOL

Admission Date to Facility:

Date of Referral:

Local Contact Agency Name: Select one:

Phone:

Transition Coordinator Name:

Referring Nursing Facility Name:			
Address:			
City:		Zip:	
Phone:			
Contact Person:			

Resident's Name:	
County of Residence:	
Medicare #:	
Medicaid #:	
Source:	

Primary Physician *(After transition, if different)*:			
Address:			
City:		Zip:	
Phone:			
Case Manager has copy of completed MDS 3.0 Section Q Checklist: Yes No			
Current Primary Physician:			
Phone:			

FINANCIAL INFORMATION

List <u>all</u> sources of income and amounts (e.g., SSA, SSI, other retirement benefits, savings, checking accounts, etc.)

SOURCE	AMOUNT	SOURCE	AMOUNT

MEDICAID ELIGIBILITY

Is resident eligible or likely to be eligible for Medicaid when/if discharged from the facility? ◯ Yes ◯ No

HCBS AVAILABILITY

Is there Home and Community Based Service (HCBS) availability? ◯ Yes ◯ No

REASON(S) FOR INSTITUTIONAL PLACEMENT

Check all reasons and provide description of circumstances at time of placement for each category. Each reason must be identified as a potential barrier and addressed in the assessment of current status below.

☐	Health Needs ◯ Acute ◯ Chronic
☐	Lack of available caregivers
☐	Lack of home and community based supports
☐	Lack of appropriate/accessible housing
☐	Mental Health Needs
☐	Other

HOUSING

Is housing available to the resident? ◯ Yes ◯ No	If "Yes" Resident will live: Select One
	If other, please list

CAREGIVER SUPPORT

Primary Caregiver's Name:	
Relationship:	
Phone:	
Caregiver Support System:	

**Describe/Discuss needs and how OR if they might be addressed in the community:*

GENERAL HEALTH ASSESSMENT

List <u>Current Diagnoses</u>:
Include current Mental Health Diagnosis(es), if applicable

**If resident has decubitus ulcers, discuss/describe stage, and treatment*

List <u>Current Medications</u>

List <u>Current Therapies</u>

List <u>Durable Medical Equipment</u>

List <u>Allergies</u>

PAIN MANAGEMENT

Does the resident suffer from pain?	◯ Yes ◯ No
If yes, please select type	Select Type

How is pain managed?

	Pharmacological		Exercise		Relaxation Exercises
	Diet		Stress Management		Other:

**Describe/Discuss how pain is managed.*

NUTRITIONAL STATUS/ASSESSMENT

Has resident's food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?	◯ Yes ◯ No If yes: Select One
Has there been weight loss during the last 3 months?	◯ Yes ◯ No

MEDICATION MANAGEMENT

Assess resident's ability to prepare and take all prescribed medications reliably and safely.

Resident is able…

ADL/IADL NEEDS

ADL Function	Independent	Needs Help	Dependent	Cannot Do
Bathing	◯	◯	◯	◯
Dressing	◯	◯	◯	◯
Grooming	◯	◯	◯	◯
Mouth care	◯	◯	◯	◯
Toileting	◯	◯	◯	◯
Transferring bed/chair	◯	◯	◯	◯
Walking	◯	◯	◯	◯
Climbing stairs	◯	◯	◯	◯
Eating	◯	◯	◯	◯

IADL Function	Independent	Needs Help	Dependent	Cannot Do
Shopping	○	○	○	○
Cooking	○	○	○	○
Using the phone and looking up numbers	○	○	○	○
Doing Housework	○	○	○	○
Doing Laundry	○	○	○	○
Driving or using public transportation	○	○	○	○
Managing finances	○	○	○	○
**Describe/Discuss needs and how OR if they might be addressed in the community:*				

MENTAL/EMOTIONAL/BEHAVIORAL ASSESSMENT

Resident…	
○ Yes ○ No	Alert/oriented, able to focus and shift attention, comprehend and recall task directions independently.
○ Yes ○ No	Somewhat dependent
○ Yes ○ No	Totally dependent due to constant disorientation, coma, persistent vegetative state, or delirium
Resident requires…	
○ Yes ○ No	Prompting (cueing, repetition, reminders) but only under stressful or unfamiliar conditions
○ Yes ○ No	Assistance and some direction in specific situations
○ Yes ○ No	Considerable assistance in routine situations
**Describe/Discuss needs and how OR if they might be addressed in the community:*	

ADVERSE BEHAVIORS

Resident exhibits/expresses…

☐	Memory deficits
☐	Verbal disruptions (yelling, threatening, excessive profanity, sexual references, etc.)
☐	Aggression toward others
☐	Disruptive, infantile, or socially inappropriate behavior
☐	Substance Abuse or history of substance abuse
☐	Delusional hallucinatory or paranoid behavior

**Describe/Discuss needs and how OR if they might be addressed in the community:*

DEPRESSIVE FEELINGS

Has resident suffered psychological stress or acute disease in the past 3 months?	◯ Yes ◯ No
If yes, please describe:	Select One

Resident exhibits/expresses…

☐	Depressed mood
☐	Sense of failure
☐	Hopelessness
☐	Thoughts of suicide
☐	Recurrent thoughts of death
	Select One

**Describe/Discuss needs and how OR if they might be addressed in the community:*

COMMUNITY RESOURCE NEEDS *(List community resource needs not addressed by HCBS)*

Are you interested in employment after discharge is complete?	◯ Yes (if yes, see below) Would you like to be referred to VR? ◯ Yes ◯ No	◯ No

Are there <u>unavailable</u> needed resources? (If yes, please list below)		◯ Yes ◯ No

REFERRALS TO AVAILABLE COMMUITY RESOURCES *(List referrals that have been or will be made…)*

Agency	Phone	Date Referred

FEASIBILITY SCALE

Medicaid Eligibility		0 = Resident will not be eligible for Medicaid upon return to the community. 1 = Resident is likely to be eligible for Medicaid upon return to the community.
HCBS Availability		0= Resident will not have access to an HCBS program upon return to the community. 1= Resident will have access to an HCBS program upon return to the community.
Safe , Affordable Housing		0= Resident will not have access to safe, affordable housing upon return to the community. 1= Resident will have access to safe, affordable housing upon return to the community.
Willing, Able Caregiver		0= There is not a willing and able caregiver. 1= There is a willing and able caregiver.
Available Mental/ Emotional/ Behavioral Supports		0= Needed mental/ emotional behavioral supports are not available 1= Needed mental/ emotional behavioral supports are available 2= No mental/ emotional behavioral supports are needed
Community Resource Availability		0= Needed community resources are not available. 1= Needed community resources are available. 2= No community resources are needed.
Manageable Health Conditions		0= Resident's health condition(s) cannot be managed in the community. 1= Resident's health condition(s) can be managed in the community.
Available ADL/ IADL Supports		0= Needed ADL/ IADL supports are not available upon return to the community. 1= Needed ADL/ IADL supports are available upon return to the community.

FEASIBILITY SCORE: _____
(Max.= 10 Points)

8- 10 = Successful transition is very likely
5- 7 = Successful transition is likely
0-4 = Successful transition is highly unlikely

Client Referred to the Following Waiver… Select One

SUMMARY: ***(Address whether or not and HOW any identified barriers might be overcome.)***

Alabama Medicaid Agency Gateway to Community Living Use Only:

MFP Eligibility Confirmed: ◯ Yes ◯ No

Date of Confirmation: